| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155115 | A. BUILDING 00<br>B. WING | 11/05/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARDINAL NURSING AND REHABILITATION CENTER | 1121 E LASALLE AVE<br>SOUTH BEND, IN 46617 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: October 29, 30, 31, November 1, 2 and 5, 2012<br><br>Facility number: 000048<br>Provider number: 155115<br>AIM number: 100275330<br><br>Survey team:<br>Kathleen (Kitty) Vargas, RN-TC<br>Lara Richards, RN<br>Heather Tuttle, RN<br><br>Census bed type:<br>SNF/NF: 118<br>Total: 118<br><br>Census payor type:<br>Medicare: 11<br>Medicaid: 97<br>Other: 10<br>Total: 118<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 11/08/12 by Suzanne Williams, RN | F0000 | **The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after December 5, 2012.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0156 SS=A | 483.10(b)(5) - (10), 483.10(b)(1)<br>NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes: | | | |

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| | A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the | | | |

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| | individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. | | | |
| | Based on record review and interview, the facility failed to ensure 2 of 3 residents reviewed for notification of the discontinuation of skilled services received notification prior to the end of services. (Residents #99 and #128)<br><br>Findings include:<br><br>1. The form titled, "Notice of Medicare Non-Coverage" for Resident #99 was reviewed on 11/2/12. The form indicated the date the resident's Medicare coverage would end was 5/28/12. The form also indicated the letter was mailed on 5/28/12 to the resident's responsible party. There was not a 48 hour notice prior to the end of Medicare skilled services.<br><br>Interview with the Social Service | F0156 | **F156 – Notice of Rights, Rules, Services, Charges** It is the practice of this provider to inform the resident both in writing and in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #99* – resident and family have been informed of Notice of Medicare Non-Coverage. This resident experienced no negative outcome related to this finding. *Resident #128* – has been discharged from the facility and moved to another state. The Notice of Medicare Non-Coverage was not provided prior to discharge, but copies were sent to family post discharge. ***How other residents*** | 12/05/2012 |

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| | Director on 11/5/12 at 8:25 a.m., indicated Resident #99 was admitted to the facility on 5/15/12. Her last day of Medicare skilled services was 5/28/12. She had 87 days of skilled Medicare services remaining. She indicated the "Notice of Medicare Non-Coverage" was to be provided to the resident or to the resident's responsible party 48 hours prior to the end of Medicare skilled services. She indicated the letter was not provided to the resident or the resident's responsible party timely.<br><br>2. The record for Resident #128 was reviewed on 11/5/12 at 8:15 a.m.. The resident was admitted to the facility on 5/15/12. She was discharged from the facility on 6/15/12.<br><br>Interview with the Social Service Director on 11/5/12 at 8:20 a.m., indicated the resident had 62 days of skilled Medicare remaining at the time of discharge. There was no evidence that a "Notice of Medicare Non-Coverage" was provided to the resident or the resident's responsible party prior to the end of Medicare skilled services.<br><br>Interview with the Social Service Director on 11/5/12 at 8:20 a.m., indicated there was no "Notice of | | ***having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents receiving Skilled Nursing Services have the potential to be affected by this finding. A facility audit will be completed by SSD/designee. This audit will ensure all residents have been given proper and timely notification for the past 90 days related to Notice of Medicare Non-Coverage. Any errors or omissions noted during this audit will be clarified and/or corrected immediately. Changes in residents receiving Skilled Nursing Services will be communicated to all responsible staff during daily meetings. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The ED/DNS/designee will be responsible for re-educating and in-servicing the SSD and other responsible staff members regarding Medicare Non-Coverage Notifications. This in-servicing will be completed on or before 12/5/12. The ED/DNS/designee will review all residents pending discontinuation of Skilled Services to ensure notification is provided within 2 days. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put*** | |

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| | Medicare Non-Coverage" provided to the resident prior to discharge.<br><br>The policy titled, "Checklist/Instructions for Issuing a Notice of Medicare Non-Coverage/Determination On Continued Stay" was provided by the Social Service Director on 11/5/12. She indicated the policy was current. The policy indicated the Notice of Medicare Non-Coverage form must be issued no later than two days (48 hours) before the proposed end of services.<br><br>3.1-4(a) | | ***into place:*** The ED/SSD/designee will be responsible for completing the CQI Audit Tool titled, “Discharge Planning” weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| F0205 SS=A | 483.12(b)(1)&(2)<br>NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR<br>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.<br><br>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.<br>Based on record review and interview, the facility failed to ensure the resident's responsible party received a copy of the facility bed hold policy upon transfer to the hospital for 1 of 2 residents reviewed for discharge of the 2 residents who met the criteria for admission, transfer, and discharge. (Resident #39)<br><br>Findings include:<br><br>Interview with Resident #39's family on 10/30/12 at 12:02 p.m., indicated | F0205 | **The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after December 5, 2012.F205 – Notice of Bed-Hold Policy Before/Upon Transfer** It is the practice of this facility to provide written information to the resident and a family member or | 12/05/2012 |

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| | they did not recall receiving a copy of the facility's bed hold policy and the policy allowing the resident to return to the facility the last time the resident was transferred to the hospital.<br><br>The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident was sent to the Emergency room for evaluation and returned to the facility on 5/26/12. Documentation in the Resident progress note on 5/26/12 at 1:00 p.m., indicated the resident's daughter was present when the resident was transferred to the hospital. There was no documentation to indicate if the resident's daughter received a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy in the resident's chart.<br><br>Interview with the Social Service Director for the Cottage Unit on 11/5/12 at 10:30 a.m., indicated that he could not find a bed hold form in the resident's record.<br><br>Interview with the Director of Nursing on 11/5/12 at 1:20 p.m., indicated the resident's family should have received or been mailed a copy of the bed hold policy. She indicated the nurse who | | legal representative that specifies the duration of the bed-hold policy under the State plan before a resident transfers to a hospital or allows a resident to go on therapeutic leave. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #39* – resident's family member/legal representative has been informed of this resident's current status. This resident experienced no negative outcome related to this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident that transfers to a hospital or goes on therapeutic leave has the potential to be affected by this finding. A facility audit will be completed by SSD/designee. This audit will ensure all residents and/or family member or legal representative of residents currently hospitalized and/or are on a therapeutic leave of absence have been given proper and timely notification regarding transfer and/or therapeutic leave and have received a copy of the facility's Bed Hold Policy and the policy allowing the resident to return to the facility. Any errors or omissions noted during this audit will be clarified and/or corrected immediately. Resident transfers | |

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| | sent the resident to the hospital was new at the time and she no longer worked at the facility.<br><br>3.1-12(a)(25)(B) | | and therapeutic leaves are reviewed in the daily meeting by the IDT. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A mandatory nursing in-service will be conducted on or before 12/5/12 by the DNS/designee. This in-service will include review of the facility Bed Hold Policy and the procedure for notification to residents and/or family members or legal representatives. Charge Nurses will be responsible for completing the Bed Hold Policy paperwork upon transfer or therapeutic leave, attaching the signed copy to the transfer paperwork and placing a copy of the signed notification in the resident's clinical record. The SSD/designee will be responsible for ensuring all residents and/or family member or legal representative have been given proper and timely notification regarding transfer and/or therapeutic leave and have received a copy of the facility's Bed Hold Policy and the policy allowing the resident to return to the facility. The ED/DNS/designee will audit the resident chart to ensure necessary paperwork has been provided to the resident/POA upon transfer or discharge. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur,*** | |

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| | | | ***i.e., what quality assurance program will be put into place:*** The ED/SSD/designee will be responsible for completing the CQI Audit Tool titled, "Discharge Planning" weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| F0223 SS=D | 483.13(b), 483.13(c)(1)(i)<br>FREE FROM ABUSE/INVOLUNTARY SECLUSION<br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of emotional abuse for 1 of 1 resident reviewed for abuse of the 1 resident who met the criteria for abuse. (Resident #62)<br><br>Findings include:<br><br>On 10/30/12 at 9:43 a.m., during an interview with Resident #62, she indicated a CNA got angry with her because she asked a question regarding her clothes, and the CNA threw her clothes at her. She indicated she told her daughter and her daughter told the Nursing staff.<br><br>During further interview on 11/1/12 at 10:34 a.m., the resident indicated no staff has been rude to her or mean since the incident with the clothes in which her daughter had already reported. | F0223 | **F223 – Free from Abuse/Involuntary Seclusion** It is the practice of this provider that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #62* – physician and family have been updated regarding this resident's current status. This resident experienced no negative psychosocial reaction or outcome related to this finding and is being treated with respect and dignity during ADL care. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents are at risk to be affected by this finding. Resident and family interviews were conducted per CQI Abuse Questionnaire devised by CMS with no findings. The ED, | 12/05/2012 |

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| | The record for Resident #62 was reviewed on 11/1/12 at 3:04 p.m. The resident's diagnoses included, but were not limited to, uncontrolled diabetes, history of stroke, obesity, depression, anxiety, and adjustment disorder.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated 3/14/12, indicated the resident was alert and oriented. She had no behaviors, and she needed some assistance with dressing.<br><br>Review of the incident form that was dated 7/27/12, indicated Resident #62 reported to her daughter that CNA #3 was assisting her with a change of clothing and mistreated her. Upon further investigation, the resident alleged to the Social Service Director earlier in the day she was having trouble deciding which article of clothing to wear, and CNA #3 balled up three articles of clothing and threw then into the resident's face and said "you decide."<br><br>The immediate action taken included CNA #3 was suspended pending results of the investigation. | | DNS/designee will be responsible for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. All staff will be re-educated regarding the various types of abuse including emotional abuse and the procedure for responding to and timely reporting of any alleged or actual abuse situation. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the ED and/or DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy. The ED, DNS/designee will be responsible for conducting this in-service. The ED, | |

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| | 155115 | A. BUILDING 00<br>B. WING | 11/05/2012 |

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| CARDINAL NURSING AND REHABILITATION CENTER | 1121 E LASALLE AVE<br>SOUTH BEND, IN 46617 |

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| | Review of the five day follow up indicated there was no psychosocial distress noted for the resident based on an assessment by Social Service Director. Other residents who were provided care by CNA #3 were interviewed to determine if care was provided appropriately and respectively. The Administrator also interviewed CNA #3 who acknowledged an unwitnessed incident occurred between the resident and herself involving three articles of clothing on 7/27/12. The CNA acknowledged she was frustrated with the resident at the time of the incident. The CNA also indicated the resident had accused her of throwing her clothes on her person at the time the incident occurred. The CNA stated she told the resident she did not throw clothes at her at the time of the incident. CNA #3 further acknowledged she did not report the allegation to her charge nurse or nurse supervisor nor documented the said incident in any manner.<br><br>Further review of the five day follow up indicated the Administrator interviewed the resident on 7/30/12. The resident stated the CNA threw three blouses in her face because she was angry at her. She further | | DNS/designee will be responsible for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | alleged CNA #3 stated to her that since she can't make up her mind of what to wear for her to go to the closet and get it herself. The resident indicated since the CNA would not and did not help her, she went to the closet and selected her clothing herself.<br><br>Interview with the Administrator on 11/1/12 at 4:45 p.m., indicated he was not notified of the incident until the next day. He further indicated he personally interviewed the resident and the CNA and the resident indicated the CNA threw the clothes at her. The CNA indicated that she was getting upset with the resident, and the resident did accuse her of throwing the clothes at her, but she did not report or tell any staff member that night. He further indicated the CNA was terminated due to not reporting the incident and the allegation was substantiated.<br><br>3.1-27(b) | | | |

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| F0225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on record review and | F0225 | **F225 – Investigate/Report** It is | 12/05/2012 |

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| | interview, the facility failed to report an allegation of abuse immediately to the Administrator for 2 of 3 allegations of abuse reviewed. (Residents #62, #86, and #131)<br><br>Findings include:<br><br>1. On 10/30/12 at 9:43 a.m., during an interview with Resident #62, she indicated a CNA got angry with her because she asked a question regarding her clothes, and the CNA threw her clothes at her. She indicated she told her daughter and her daughter told the Nursing staff.<br><br>During further interview on 11/1/12 at 10:34 a.m., the resident indicated no staff has been rude to her or mean since the incident with the clothes in which her daughter had already reported.<br><br>The record for Resident #62 was reviewed on 11/1/12 at 3:04 p.m. The resident's diagnoses included, but were not limited to, uncontrolled diabetes, history of stroke, obesity, depression, anxiety, and adjustment disorder.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated 3/14/12, indicated | | the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and thoroughly investigated per facility policy. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #62, #86, #131* – physicians and families have been updated regarding each resident's current status. These residents experienced no negative psychosocial reaction or outcome related to this finding. Any allegation of abuse will be reported immediately to the ED/DNS. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents are at risk to be affected by this finding. Resident and family interviews will be conducted per CQI Abuse Questionnaire devised by CMS with no findings. The ED, DNS/designee will be responsible for conducting random facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. The staff will be interviewed by ED/designee to ensure staff is knowledgeable regarding | |

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| | the resident was alert and oriented. She had no behaviors, and she needed some assistance with dressing.<br><br>Review of the incident form that was dated 7/27/12, indicated Resident #62 reported to her daughter that CNA #3 was assisting her with a change of clothing and mistreated her. Upon further investigation, the resident alleged to the Social Service Director earlier in the day she was having trouble deciding which article of clothing to wear, and CNA #3 balled up three articles of clothing and threw then into the resident's face and said "you decide."<br><br>The immediate action taken included CNA #3 was suspended pending results of the investigation.<br><br>Review of the five day follow up indicated there was no psychosocial distress noted for the resident based on an assessment by Social Service Director. Other residents who were provided care by CNA #3 were interviewed to determine if care was provided appropriately and respectively. The Administrator also interviewed CNA #3 who acknowledged an unwitnessed incident occurred between the | | reporting of abuse. All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. All staff will be re-educated regarding the various types of abuse including emotional abuse and the procedure for responding to and timely reporting of any alleged or actual abuse situation. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the ED and/or DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy. The ED, DNS/designee will be responsible for conducting this in-service. The ED, DNS/designee will be responsible for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and | |

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| | resident and herself involving three articles of clothing on 7/27/12. The CNA acknowledged she was frustrated with the resident at the time of the incident. The CNA also indicated the resident had accused her of throwing her clothes on her person at the time the incident occurred. The CNA stated she told the resident she did not throw clothes at her at the time of the incident. CNA #3 further acknowledged she did not report the allegation to her charge nurse or nurse supervisor nor documented the said incident in any manner.<br><br>Further review of the five day follow up indicated the Administrator interviewed the resident on 7/30/12. The resident stated the CNA threw three blouses in her face because she was angry at her. She further alleged CNA #3 stated to her that since she can't make up her mind of what to wear for her to go to the closet and get it herself. The resident indicated since the CNA would not and did not help her, she went to the closet and selected her clothing herself.<br><br>Interview with the Administrator on 11/1/12 at 4:45 p.m., indicated he was not notified of the incident until | | Investigation. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | the next day. He further indicated he personally interviewed the resident and the CNA, and the resident indicated the CNA threw the clothes at her. The CNA indicated that she was getting upset with the resident, and the resident did accuse her of throwing the clothes at her, but she did not report or tell any staff member that night. He further indicated the CNA was terminated due to not reporting the incident timely.<br><br>2. The allegation of Resident to Resident abuse dated 8/20/12, involving Resident #86 and #131, was reviewed on 11/2/12 at 1:34 p.m.<br><br>The event was witnessed by the previous Dietary Food Manager on 8/19/12. She observed Resident #86 standing in close proximity to Resident #131, and without apparent provocation or invitation, Resident #86 began to kiss Resident #131 upon her lips.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/28/12, indicated Resident #131 had a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment.<br><br>The quarterly MDS assessment dated | | | |

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| | 9/6/12, indicated Resident #86 had a BIMS score of 12, which indicated moderate cognitive impairment.<br><br>Resident #86 was referred to psych services, and other female residents were interviewed to see if Resident #86 tried to kiss them.<br><br>Interview with the Administrator on 11/2/12 at 2:40 p.m., indicated the previous Dietary Food Manager was attending an IDT(Interdisciplinary Team) meeting on 8/20/12. In that meeting she announced to the team that she witnessed Resident #86 kissing Resident #131. She further indicated at that time, she did not report the incident immediately to the Administrator or anyone else. The Administrator indicated the event took place on 8/19/12 and was reported to him on 8/20/12.<br><br>3.1-28(c) | | | |

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| F0226 SS=D | 483.13(c)<br>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to follow the Abuse policy related the timeliness of reporting an allegation of abuse immediately to the Administrator for 2 of 3 allegations of abuse reviewed. (Residents #86, #62, and #131)<br><br>Findings include:<br><br>1. On 10/30/12 at 9:43 a.m., during an interview with Resident #62, she indicated a CNA got angry with her because she asked a question regarding her clothes, and the CNA threw her clothes at her. She indicated she told her daughter and her daughter told the Nursing staff.<br><br>During further interview on 11/1/12 at 10:34 a.m., the resident indicated no staff has been rude to her or mean since the incident with the clothes in which her daughter had already reported.<br><br>The record for Resident #62 was | F0226 | **F226 – Develop/Implement Abuse/Neglect, etc Policies** It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #62, #86, #131* –physician and families have been updated regarding each resident's current status. These residents experienced no negative psychosocial reaction or outcome as a result of this finding. Any allegation of abuse will be reported immediately to the ED/DNS. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents are at risk to be affected by this finding. Resident and family interviews were conducted per CQI Abuse Questionnaire devised by CMS with no findings. The ED, DNS/designee will be responsible | 12/05/2012 |

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| | reviewed on 11/1/12 at 3:04 p.m. The resident's diagnoses included, but were not limited to, uncontrolled diabetes, history of stroke, obesity, depression, anxiety, and adjustment disorder.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated 3/14/12, indicated the resident was alert and oriented. She had no behaviors, and she needed some assistance with dressing.<br><br>Review of the incident form that was dated 7/27/12, indicated Resident #62 reported to her daughter that CNA #3 was assisting her with a change of clothing and mistreated her. Upon further investigation, the resident alleged to the Social Service Director earlier in the day she was having trouble deciding which article of clothing to wear, and CNA #3 balled up three articles of clothing and threw then into the resident's face and said "you decide."<br><br>The immediate action taken included CNA #3 was suspended pending results of the investigation.<br><br>Review of the five day follow up indicated there was no psychosocial | | for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** All staff in-services will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to Abuse Prohibition, Reporting and Investigation and review of the Elder Justice Act. All staff will be re-educated regarding the various types of abuse including emotional abuse and the procedure for responding to and timely reporting of any alleged or actual abuse situation. Any allegation or statement regarding resident abuse or mistreatment will be reported immediately to the ED and/or DNS. The facility will immediately initiate a full investigation as well as ensure notification to the MD, family, ISDH and other agencies as outlined in the facility policy. The ED, DNS/designee will be responsible for conducting this in-service. The ED, DNS/designee will be responsible | |

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| | distress noted for the resident based on an assessment by Social Service Director. Other residents who were provided care by CNA #3 were interviewed to determine if care was provided appropriately and respectively. The Administrator also interviewed CNA #3 who acknowledged an unwitnessed incident occurred between the resident and herself involving three articles of clothing on 7/27/12. The CNA acknowledged she was frustrated with the resident at the time of the incident. The CNA also indicated the resident had accused her of throwing her clothes on her person at the time the incident occurred. The CNA stated she told the resident she did not throw clothes at her at the time of the incident. CNA #3 further acknowledged she did not report the allegation to her charge nurse or nurse supervisor nor documented the said incident in any manner.<br><br>Further review of the five day follow up indicated the Administrator interviewed the resident on 7/30/12. The resident stated the CNA threw three blouses in her face because she was angry at her. She further alleged CNA #3 stated to her that since she can't make up her mind of | | for conducting facility interviews with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting and Investigation. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weeks then monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | what to wear for her to go to the closet and get it herself. The resident indicated since the CNA would not and did not help her, she went to the closet and selected her clothing herself.<br><br>Interview with the Administrator on 11/1/12 at 4:45 p.m., indicated he was not notified of the incident until the next day. He further indicated he personally interviewed the resident and the CNA, and the resident indicated the CNA threw the clothes at her. The CNA indicated that she was getting upset with the resident, and the resident did accuse her of throwing the clothes at her, but she did not report or tell any staff member that night. He further indicated the CNA was terminated due to not reporting the incident timely.<br><br>2. The allegation of Resident to Resident abuse dated 8/20/12, involving Resident #86 and #131, was reviewed on 11/2/12 at 1:34 p.m.<br><br>The event was witnessed by the previous Dietary Food Manager on 8/19/12. She observed Resident #86 standing in close proximity to Resident #131 and, without apparent provocation or invitation, Resident #86 began to kiss Resident #131 | | | |

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| | upon her lips.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/28/12, indicated Resident #131 had a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment.<br><br>The quarterly MDS assessment dated 9/6/12, indicated Resident #86 had a BIMS score of 12, which indicated moderate cognitive impairment.<br><br>Resident #86 was referred to psych services, and other female residents were interviewed to see if Resident #86 tried to kiss them.<br><br>Interview with the Administrator on 11/2/12 at 2:40 p.m., indicated the previous Dietary Food Manager was attending an IDT (Interdisciplinary Team) meeting on 8/20/12. In that meeting she announced to the team that she witnessed Resident #86 kissing Resident #131. She further indicated at that time, she did not report the incident immediately to the Administrator or anyone else. The Administrator indicated the event took place on 8/19/12 and was reported to him on 8/20/12.<br><br>Review of the current 9/12 Abuse | | | |

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| | 155115 | A. BUILDING 00<br>B. WING | 11/05/2012 |

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| | Prohibition, Reporting, and Investigation Policy and Procedure, provided by the Administrator, indicated, "All abuse allegations/abuse must be reported to the Executive Director immediately and to the resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to an including immediate termination."<br><br>3.1-28(a) | | | |

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| F0241 SS=D | 483.15(a)<br>DIGNITY AND RESPECT OF INDIVIDUALITY<br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br>Based on observation, record review and interview, the facility failed to ensure each resident's dignity was enhanced related to the labeling of a resident, pulling a resident backwards down the hall and being exposed while in bed for 1 of 1 resident reviewed for dignity. (Resident #118)<br><br>Findings include:<br><br>1. On 10/29/2012 at 11:56 a.m., Resident #118 was observed in a geri recliner seated in the dining room. At that time, CNA #2 referred to the resident as a "feeder" and indicated the resident ate in the back of the dining room where she was fed by staff. There were other residents close to the CNA, and heard the CNA use the term "feeder."<br><br>On 10/29/12 at 12:12 p.m., during the noon meal in the first floor dining room, the Maintenance Supervisor walked into dining room holding four folding chairs. At that time, he stated to the staff "Do you want these chairs | F0241 | **F241 – Dignity and Respect of Individuality** It is the practice of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #118 –* physician and family have been updated regarding this resident's current status. This resident's wheelchair has been serviced by maintenance and is in working order. This resident experienced no negative psychosocial reaction or outcome related to this finding. Resident will be provided appropriate covering at all times and resident will be referred to by her given name when being addressed. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident who requires total assist with ADLs such as eating, dressing and wheelchair mobility has the | 12/05/2012 |

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| | for the feeders?"<br>There were other residents in the dining room waiting for lunch to be served, and heard the Maintenance Supervisor use the term "feeders."<br><br>On 10/31/12 at 3:36 p.m. the resident was observed in bed from the hallway. At that time, the privacy curtain was pulled in between the resident in bed one and Resident #118. Only the resident's upper body was seen from the hallway. The resident was observed lying sideways in bed with both of her legs bent towards her body. The resident's top sheet had been removed from her body and her pubic area was exposed. The resident was not wearing pants or an incontinent brief.<br><br>On 11/1/12 at 9:27 a.m., CNA #4 was observed pulling the resident out of the dining room and down the hall backwards in her geri recliner. Interview with CNA #4 at that time, indicated she knew that she was not supposed to pull residents down the hall backwards but the chair wheels would not allow her to push the resident forward.<br><br>The record for Resident #118 was reviewed on 11/1/12 at 9:30 a.m. The resident was admitted to facility on | | potential to be affected by this finding. Customer Care Rounds will be conducted daily by Department Leaders on all units including all shifts. Any resident dignity issues noted during these Customer Care Rounds will be corrected immediately. An all staff in-service will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to resident dignity and privacy issues including resident "labeling" and pulling a resident's wheelchair backwards. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** An all staff in-service will be conducted on or before 12/5/12. This in-service will include review of the facility policy related to resident dignity issues including resident "labeling" and pulling a resident's wheelchair backwards. This in-service will also include review of the facility policy related to protecting a resident's privacy during care and when residents are in bed. The DNS/designee will be responsible for conducting this in-service. In addition, Customer Care Rounds by Department Leaders will be conducted daily on all units including all shifts. Any resident dignity issues noted during these Customer Care Rounds will be corrected immediately. ***How the corrective action(s) will be*** | |

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| | 3/5/12. The resident's diagnoses included, but were not limited to, renal failure, malnutrition, dementia, failure to thrive, anxiety, and chronic pain.<br><br>Review of the Minimum Data Set (MDS) assessment dated 8/25/12, indicated the resident was cognitively impaired, rarely understands and was rarely understood. The resident was totally dependent on staff for dressing, eating, and personal hygiene.<br><br>Review of the current plan of care plan dated 3/29/12 and updated 8/12, indicated the resident has cognitive loss. The Nursing approaches were to ensure privacy and dignity of the resident.<br><br>Interview with the Third Floor Unit Manager on 11/1/12 at 11:23 a.m., indicated the resident thrashes a lot in bed and startles very easily when staff were trying to provide care. She further indicated the resident does lay down after meals without her bottoms and an incontinent brief on. The Unit Manager also indicated at the time, she was unaware the residents could not be referred to as "feeder."<br><br>3.1-3(t) | | ***monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/SSD/designee will be responsible for completion of the CQI Audit tool titled, "Dignity/Privacy" daily for 3 weeks, weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| F0242 SS=D | 483.15(b)<br>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>Based on observation, record review and interview, the facility failed to ensure each resident's choice was honored related to tub baths, preference on going to bed at night and how many times a week a shower was given for 2 of 3 residents reviewed for choices of the 3 residents who met the criteria for choices. (Residents #31 and #76)<br><br>Findings include:<br><br>1. Interview with Resident #31 on 10/29/12 at 2:23 P.M., indicated he usually went to bed around 8:00 p.m. He further indicated he needed assistance to go to bed and his preference was to go to bed right after supper which was around 6:30 p.m.<br><br>The record for Resident #31 was reviewed on 10/31/12 at 1:59 p.m. The resident's diagnoses included, but were not limited to, anemia, | F0242 | **F242 – Self-Determination – Right to Make Choices** It is the intent of this provider that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or life in the facility that are significant to the resident. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #31* – an Activity Assessment and "Preferences for Daily Customary Routines" Questionnaire was completed for this resident. The care plan and Nurse Aide Assignment Sheet has been updated to reflect his bedtime preference. *Resident #76* – an Activity Assessment and "Preferences for Daily Customary Routines" Questionnaire was completed for this resident. The care plan and Nurse Aide | 12/05/2012 |

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| | osteoarthritis, chronic renal failure, stroke, and oral cancer.<br><br>Review of the 8/21/12 significant change Minimum Data Set (MDS) assessment indicated the resident was alert and oriented, and had no behavior or mood problems. The resident indicated it was very important to choose his own bedtime. The resident was an extensive assist with one person help for bed mobility, transfers, and toileting needs.<br><br>Review of the current 7/31/12 plan of care indicated the resident makes poor choices as evidenced by history of refusals of personal care. The Nursing approaches were to allow for choice about time or type of care provided, allow resident to express feelings and vent feeling of frustrations, and allow resident to participate in his plan of care as much as possible.<br><br>Review of the care card for the third floor indicated the resident's preference of wanting to go bed right after supper was not listed on the care card. The only preference was to place the urinal on bed side table uncovered and that he preferred a shower before breakfast. | | Assignment Sheet has been updated to reflect her bathing preference. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by this finding and will be identified through a facility audit. This audit will be completed by the Activity Director/designee. Each resident or family member/responsible party will have a "Preferences for Daily Customary Routines" Questionnaire completed as well as an updated Activity Assessment. These completed Questionnaires and Assessments will be reviewed by the IDT. Each resident's care plan and Nurse Aide Assignment Sheet will be updated as appropriate to reflect their personal preferences and choices regarding their daily routines and schedules. "Preferences for Daily Customary Routines" are completed on admission, annually, quarterly and with significant change. Any changes to resident preferences and choices regarding their daily routines and schedules will be communicated and followed up with in the daily meetings. This will ensure direct care staff is aware of resident personal preferences and choices for daily activities such as bedtimes and bathing choices. An all staff | |

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| | Interview with CNA #6 on 10/31/12 at 3:47 p.m., indicated he usually works the evening shift on the third floor and was very familiar with the resident. He further indicated he knew the resident preferred to go to bed right after supper, and when he works he honors the resident's choice. CNA #6 further indicated he does know that his choice was not always honored, especially when new CNAs were working, and they do not know the resident.<br><br>Interview with LPN #3 on 11/1/12 at 3:44 p.m., indicated she did know the resident preferred to be laid down right after dinner. However, she further indicated that it really depended on who was working if the resident got to lay down right after supper and if they knew his preferences.<br><br>During interview on 11/1/12 at 4:13 p.m., the Third Floor Unit Manager indicated she was aware of the resident's preferences to go to bed after supper. She further indicated his preference was not on the CNA care card. | | in-service will be conducted on or before 12/5/12. The DNS/designee will be responsible for conducting this in-service. This in-service will include review of the facility policy related to resident's rights and choices.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** An all staff in-service will be conducted on or before 12/5/12. The DNS/designee will be responsible for conducting this in-service. This in-service will include review of the facility policy related to resident's rights and choices. Each resident or family member/responsible party will have a "Preferences for Daily Customary Routines" Questionnaire completed as well as an updated Activity Assessment. These completed Questionnaires and Assessments will be reviewed by the IDT. Each resident's care plan and Nurse Aide Assignment Sheet will be updated to reflect their personal preferences and choices regarding their daily routines and schedules. This will ensure direct care staff is aware of resident personal preferences and choices for daily activities such as bed times and bathing choices. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance*** | |

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| | | | ***program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tool titled, "Accommodation of Needs" daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |
| | 2. Interview with Resident #76 on 10/30/12 at 9:39 a.m., indicated she preferred to have showers 4 times per week. She indicated she received showers two times per week. She also indicated she preferred to take a tub bath instead of a shower.<br><br>The resident resided on the third floor of the facility. She was observed on 10/31/12 at 11:10 a.m., seated in a wheelchair in her room. Interview with the resident at that time, indicated she received showers on Mondays and on Wednesday. She stated she just had a shower. She indicated there was no bathtub in the facility, and she indicated she had asked in the past and was told there was no bath tub. She indicated if there was a bathtub she would be using it. | | | |

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| | The record for Resident #76 was reviewed on 11/2/12 at 2:07 p.m. The Annual Minimum Data (MDS) assessment dated 2/13/12, indicated the resident felt it was "very important" for her to choose between a tub bath, shower, or sponge bath.<br><br>The Quarterly MDS, completed on 9/16/12, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.<br><br>Interview with CNA #1 on 11/1/12 at 9:48 a.m., indicated the shower room on the third floor did not have a bath tub. She indicated she was not aware of any bath tubs in the facility. She indicated that if a resident wanted a shower more often than two times per week, she would make out a behavior sheet and then the staff would be aware of the resident's request. She indicated Resident #76 had never informed her that she wanted a shower more often than 2 times per week. She also indicated the resident had not requested a tub bath be given instead of a shower.<br><br>Interview with the Social Service Director on 11/2/12 at 9:55 a.m., indicated she had never been informed of any resident's request for | | | |

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| | a bath. She indicated if a resident preferred a shower more often than 2 times per week, the staff were to accommodate that request.<br><br>On 11/5/12 at 8:50 a.m., interview with the Director of Nursing indicated there was a functional bathtub in the first floor shower room that could be used by residents who desired to take tub baths. She indicated she was not aware the resident desired a tub bath or showers more frequently than two times per week.<br><br>3.1-3(u)(3) | | | |

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| F0278 SS=A | 483.20(g) - (j)<br>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br>Based on observation, record review and interview, the facility failed to ensure the resident's comprehensive assessment was accurate related to hospice and dental status for 1 of 1 resident reviewed for hospice and for 1 of 3 residents reviewed for dental services of the 4 residents who met | F0278 | **F278 – Assessment Accuracy/Coordination/Certified** It is the intent of this provider that each assessment must accurately reflect the resident's status. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident* | 12/05/2012 |

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| | the criteria for dental. (Residents #80 and #105)<br><br>Findings include:<br><br>1. The record for Resident #105 was reviewed on 11/2/12 at 8:53 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, chronic anemia, cardiac arrhythmia, chronic renal failure, dementia, expressive aphasia, stroke, and failure to thrive.<br><br>Review of Physician Orders dated 1/25/12, indicated the resident was admitted to Hospice.<br><br>Review of the quarterly 10/4/12 Minimum Data Set (MDS) assessment indicated the section "Health Conditions" did not have the resident coded as having a condition or chronic disease that may result in a life expectancy of less than 6 months. Hospice care was indicated on the MDS.<br><br>Review of the Hospice Certification and Plan of Treatment signed by the Physician on 10/12/12, indicated the Physician had certified this patient was under his care and to the best of his medical knowledge and given the data available the resident had the life | | *#105* – MDS has been modified to accurately reflect her current status. This resident experienced no negative outcome related to this finding. *Resident #80* – MDS has been modified to accurately reflect her dental/oral status. The resident and family were offered dental services and declined this service. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident requiring a comprehensive assessment has the potential to be affected by this finding. A facility audit will be completed by the MDS Coordinator/designee. All resident care plans will be reviewed and compared to the most recent comprehensive and supplemental assessments during the next 90 days by the IDT to ensure any resident receiving Hospice Services and any resident that requires dental services are accurately assessed and coded. This review will be completed by 12/5/2012. The Facility Activity Report and physician orders will be reviewed daily by all disciplines to ensure information regarding resident condition such as oral/dental issues, Hospice orders and physician's orders are utilized to complete comprehensive and supplemental assessments as well as to update each resident's plan of care. All disciplines will | |

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| | expectancy of six months or less if the illness runs its normal course. The Physician authorized hospice care as outlined.<br><br>Interview with the MDS Coordinator on 11/2/12 at 11:00 a.m., indicated she was aware the resident was receiving hospice but further indicated the coding on the MDS was inaccurate related to the life expectancy of six months to live. | | participate in the development and ongoing revisions to the plan of care. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 12/5/12. This in-service will include review of the facility policy related to accuracy of completion of comprehensive and supplemental assessments including any resident receiving Hospice Services and any resident that requires dental services. It will also review the care plan process. The DNS/designee is responsible for conducting this in-service. The Facility Activity Report and physician orders will be reviewed daily by all disciplines to ensure information regarding resident condition such as oral/dental issues, Hospice orders and physician's orders are utilized to complete comprehensive and supplemental assessments as well as to update each resident's plan of care. All disciplines will participate in the development and ongoing revisions to the plan of care. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the CQI Tool titled, "Care Plan Updating" will be completed | |

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| | 2. Resident #80 was observed on 10/30/12 at 11:13 a.m. She had broken teeth noted on the bottom portion of her mouth.<br><br>The record for Resident #80 was reviewed on 10/31/12 at 12:22 p.m. She had diagnoses that included, but were not limited to, dementia and adult failure to thrive.<br><br>The significant change Minimum Data Set (MDS) assessment, dated 5/16/12, was reviewed. It indicated the resident had no dental problems. It did not indicate the resident had obvious or likely cavity or broken natural teeth.<br><br>There was a care plan dated 3/2/12, that indicated the resident had caries, missing teeth /poor oral hygiene.<br><br>Interview with the MDS Coordinator on 10/31/12 at 3:02 p.m., indicated the resident had some missing and broken teeth. She indicated the | | weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | significant change MDS was inaccurately coded.<br><br>3.1-31(d) | | | |

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| F0282 SS=E | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, record review, and interview, the facility failed to ensure Physician's orders and the plan of care were followed as written related to fall interventions not in place for 1 of 3 residents of the 6 residents who met the criteria for accidents, nutritional supplements not provided as ordered for 2 of 3 residents of the 6 residents who met the criteria for nutrition, not monitoring skin conditions weekly for 1 of 3 residents of the 3 residents who met the criteria for skin conditions non-pressure related, and not monitoring the apical pulse prior to giving Digoxin (a heart medication) and not notifying the Physician of elevated blood sugars for 2 of 10 residents reviewed for unnecessary medications. (Residents #15, #31, #36, #68, and #137)<br><br>Findings include:<br><br>1. On 10/30/12 at 2:08 p.m., Resident #68 was observed picking at a scabbed area above his knuckle on his left hand. | F0282 | **F282 - Services by Qualified Persons/Per Care Plan** It is the practice of this provider that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #15* – physician has been notified of resident's pulse and blood pressure. Resident's apical pulse is being obtained and recorded prior to giving Digoxin. This resident experienced no negative outcome related to this finding. *Resident #31*- has experienced no further weight loss and has been receiving the physician ordered supplement as well as fortified mashed potatoes with lunch and supper. The physician and the responsible party were made aware of this resident's current nutritional status. *Resident #36* - has experienced no further falls. His fall care plan and Nurse Aide Assignment Sheet has been reviewed and updated to reflect his current status. *Resident#68* - physician and family has been | 12/05/2012 |

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| | On 11/1/12 at 9:27 a.m., and 2:59 p.m., the resident was seated in a chair in the Cottage dining room. The resident was again observed picking at the scab on his left hand.<br><br>The record for Resident #68 was reviewed on 10/31/12 at 2:07 p.m. The resident's diagnoses included, but were not limited to, diabetes and behavior disturbance.<br><br>A Physician's order dated 10/8/12, indicated the resident was to have bactroban ointment applied to the top of his left hand and to the top of his left arm twice a day for 10 days then discontinue, due to picking at the sore on the top of his left hand.<br><br>The Weekly Skin Summaries dated 10/8, 10/16 and 10/30/12, indicated the resident had no changes in condition since the last weekly summary. The form indicated the resident had "no skin areas."<br><br>The plan of care dated 9/20/12, indicated the resident was at risk for skin breakdown due to incontinence, decreased mobility due to the diagnoses of diabetes, heart disease, cancer, memory problems, and picks at skin. The interventions indicated | | updated and informed of this resident's current skin condition and past and recent accucheck results and any accucheck results outside the physician ordered parameters. The care plan was updated to reflect this resident's current skin condition. This resident experienced no negative outcome as a result of this finding. *Resident #137*- has experienced no weight loss and lab values are within normal limits. He has been receiving the physician ordered cottage cheese at all meals. The physician and the responsible party were made aware of this resident's current nutritional status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will include review of the following: fall care plan review, nutritional supplement orders, skin condition review, medication administration review and blood glucose monitoring review. The most current Physician Rewrite Sheet will be compared by the Nurse Management Team/designee to MARs, care plans and Nurse Aide Assignment Sheets to ensure all physician orders are being followed as written and that all related care | |

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| | the resident was to be encouraged/redirected to not pick at his skin and assess/document skin condition weekly and as needed and to notify the Physician of abnormal findings.<br><br>Interview with LPN #2 on 11/5/12 at 10:45 a.m., indicated the issue with the resident's hand was reoccurring and should have been documented on the weekly skin assessment sheet.<br><br>A Physician's order dated 5/30/12 and listed as current on the 10/12 Physician's Order Summary (POS), indicated the resident was to receive accuchecks (a test to monitor the blood sugar) twice a day at 7:00 a.m. and 4:00 p.m. The Physician was to be called if the blood sugar was greater than 200.<br><br>Review of the August, September, and October 2012 Blood glucose monitoring sheets, indicated the resident's blood sugar was above 200 on the following dates and times; however, the resident's physician was not notified as ordered:<br><br>8/6 4:00 p.m., blood sugar 256, 8/25 4:00 p.m., blood sugar 216, and 8/29/12 4:00 p.m., blood sugar 214. | | plans are accurately reflecting each resident's current status. Any discrepancies noted during this review will be clarified and/or corrected at the time noted. A mandatory nursing in-service will be conducted on or before 12/5/12 by the DNS/designee. This in-service will include review of the facility policy related to following established physician's orders and Care Plan Review and Maintenance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted on or before 12/5/12 by the DNS/designee. This in-service will include review of the facility policy related to following established physician's orders and Care Plan Review and Maintenance. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans specifically related to falls, nutritional supplements, follow up to non-pressure skin conditions, obtaining and recording vital signs prior to medication administration and adherence to physician call parameters related to blood glucose monitoring and accucheck results. The most current Physician Rewrite Sheet will be compared by the Nurse Management Team/designee to MARs, care plans and Nurse Aide Assignment Sheets to ensure all | |

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| | 9/8 4:00 p.m., blood sugar 244, 9/9 4:00 p.m., blood sugar 271, 9/12 4:00 p.m., blood sugar 238, and 9/23/12 4:00 p.m., blood sugar 207.<br><br>10/22 4:00 p.m., blood sugar 238 and 10/23/12 4:00 p.m., blood sugar 208.<br><br>The current plan of care indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia (high or low blood sugar) related to use of glucose lowering medications and/or diagnosis of diabetes mellitus. The interventions indicated to document abnormal findings and notify the physician.<br><br>Interview with the Assistant Director of Nursing on 11/2/12 at 9:40 a.m., indicated the physician should have been notified if the resident's blood sugar was greater than 200 as ordered.<br><br>2. The record for Resident #15 was reviewed on 10/31/12 at 9:33 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation (an irregular heartbeat).<br><br>The plan of care dated 6/6/12 and reviewed 9/12, indicated the resident was at risk for adverse drug reactions | | physician orders are being followed as written and that all related care plans are accurately reflecting each resident's current status. Any discrepancies noted during this review will be clarified and/or corrected at the time noted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility CQI program. The DNS/designee will be responsible for completion of the CQI Audit tool titled, "Care Plan Updating" weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 12/5/12. | |

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| | related to receiving digoxin (a heart medication) for the diagnosis of atrial fibrillation. One of the interventions indicated the resident's apical pulse was to be checked prior to giving the medication.<br><br>Review of the October 2012 Medication Administration Record (MAR), indicated there was no pulse documented prior to giving the medication on the following dates: 10/3, 10/7, 10/8, 10/9, 10/11, 10/12, 10/13, 10/14, 10/17, 10/18, 10/19, 10/22, 10/23, 10/24, 10/26-10/29, and 10/31/12.<br><br>The September 2012 MAR, indicated no pulse was documented on 9/3, 9/11, 9/13, 9/14, 9/24 and 9/25/12.<br><br>Review of the August 2012 MAR, indicated no pulse was documented on 8/8, 8/9, 8/10, 8/22, and 8/23/12.<br><br>Interview with the Assistant Director of Nursing on 11/2/12 at 9:45 a.m., indicated the resident's apical pulse should have been checked and documented prior to giving the digoxin.<br><br>3. On 10/31/12 at 12:25 p.m., Resident #31 was observed in the dining room eating his lunch meal. At | | | |

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| | that time, the resident was served a pureed diet. The resident had a carton of chocolate milk and cup of an orange drink. There was no can of Ensure or another cup with the Ensure in it by his lunch tray.<br><br>On 11/1/12 at 12:50 p.m., the resident was observed eating his lunch in the dining room. The resident was served a pureed lunch that consisted of broccoli, noodle casserole, a breadstick, and a dessert. The resident did not receive fortified mashed potatoes. The resident was served a carton of chocolate milk and glass of fruit punch. The resident did not receive any Ensure supplement.<br><br>Interview with the resident at that time, indicated sometimes he gets the ensure sometimes he does not.<br><br>Interview with Dietary Aid #1 on 11/1/12 at 12:58 p.m., indicated she did not know if the resident was to receive the fortified mashed potatoes. She further indicated everyone who gets fortified foods also gets the regular entree as well.<br><br>The record for Resident #31 was reviewed on 10/31/12 at 1:59 p.m. The resident's diagnoses included, | | | |

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| | but were not limited to, anemia, osteoarthritis, chronic renal failure, stroke, and oral cancer.<br><br>Review of Physician Orders on the current recap dated 10/12, with the original order date of 5/22/12, indicated Ensure Plus eight ounce 1 can at meals.<br><br>Review of Dietary Progress Notes dated 5/18/12, indicated the resident was to receive fortified mashed potatoes with lunch and supper.<br><br>The current 9/12 plan of care indicated the resident had the potential for alteration in nutrition related to being on a mechanically altered and therapeutic diet. The resident received supplements to help meet nutritional needs. The Nursing approaches were to provide adaptive equipment, provide supplements per Physician orders, monitor weights and report significant weight changes to the Physician and family.<br><br>Interview with the Director of Nursing on 11/1/12 at 2:00 p.m., indicated the Ensure supplement was sent to the units by the dietary department and placed on the resident's trays.<br><br>Interview with the Consultant Dietary | | | |

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| | Food Manager on 11/1/12 at 2:00 p.m., indicated the Ensure supplement was to be placed on the food trays during the meal times from dietary. She further indicated she was unaware the resident was supposed to be receiving fortified mashed potatoes all along.<br><br>4. On 10/31/12 at 10:37 a.m., and 11:25 a.m., Resident #36 was observed sitting in a broda wheelchair in his room. The resident was observed with a hoyer lift pad underneath him. At that time, there was no staff in the resident's room. The resident was in the room with his roommate.<br><br>On 10/31/12 at 1:37 p.m., CNA #5 and the Third Floor Unit Manager were going to place the resident in bed using the hoyer lift. The resident was lifted by the hoyer and placed into the bed. At that time, there was no dycem (a piece of adhesive material to prevent the resident from sliding forward) noted in the resident's chair. CNA #5 indicated at the time that she did know the resident was to have a dycem in his wheelchair. She further indicated she had laid him down after breakfast to change his brief and then placed him back into the wheelchair. | | | |

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| | The record for Resident #36 was reviewed on 10/31/12 at 8:57 a.m. The resident's diagnoses included, but were not limited to, cataracts, high blood pressure, dementia, osteoarthritis, chronic pain syndrome, depressive disorder, and amputation of his arm.<br><br>Review of Physician Orders dated 10/26/12, indicated to utilize a broda wheelchair for positioning and comfort. Another Physician Order dated 10/18/12, indicated to add dycem to the wheelchair.<br><br>Review of the current plan of care dated 2/25/11 and updated on 10/25/12 indicated the resident was at risk for falls due to impaired functional ability, stroke, tends to fall asleep in wheelchair and will refuse to lay down, slides down in bed/chair, history of falls, and had a history of crawling out of bed. The Nursing approaches were to asses the resident when he was tired, therapy screen for a wheelchair, offer resident pajama pants, a scoop mattress, extra long high low bed to be kept in lowest position, do not leave unattended in wheelchair in his room, and a dycem in the wheelchair. | | | |

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| | Interview with the Third Floor Unit Manager on 10/31/12 at 2:00 p.m., indicated the dycem had not been placed in this chair because it was a new chair for the resident.<br><br>Interview with Third Floor Unit Manager on 11/2/12 at 3:00 p.m., indicated the resident should not be left alone in his room due to his high risk for falls, and he should have a dycem in his wheelchair all the time.<br>5. Resident #137 was observed on 10/31/12 at 8:29 a.m., in his bed. The resident had just received his breakfast tray. He was served 8 ounces of 2% milk (not lactose free), 2 bowls of hot cereal, eggs, sausage and grapefruit slices. He was not served cottage cheese.<br><br>On 10/31/12 at 12:40 p.m., the resident had his lunch tray, he did not receive cottage cheese.<br><br>On 11/1/12 at 12:45 p.m., the resident was eating lunch, he was served broccoli, ambrosia, garlic bread and chicken with spaghetti noodles. The resident did not receive cottage cheese.<br><br>The resident was in the Main Dining Room on 11/2/12 at 8:48 a.m. He had his breakfast tray. He was served | | | |

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| | lactose free milk, sausage and biscuit, 2 bowls of hot cereal and 2 boiled eggs. There was an eight ounce carton of 2% milk on his tray. There was no cottage cheese served to the resident. The Speech Language Pathologist was seated next to the resident.<br><br>Interview on 11/2/12 at 10:35 a.m., with the Speech Language Pathologist, indicated the resident was not served cottage cheese with his breakfast on 11/2/12. She also indicated he had a glass of milk and a carton of milk.<br><br>The record for Resident #137 was reviewed on 10/31/12 at 9:06 a.m. The resident had diagnoses that included, but were not limited to, end stage renal disease and hypertension. The resident received dialysis three times per week.<br><br>There was a care plan dated 10/30/12 that indicated:<br>Potential for alteration in nutrition related to resident requires therapeutic diet related to end stage renal disease, hypertension and receives dialysis.<br>Some of the interventions included:<br>-fortified cereal at breakfast, cottage cheese three times a day and Nepro | | | |

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| | -monitor weight<br>-diet per physician's order<br><br>There was a Physician Order dated 10/15/12, that indicated to add cottage cheese 1/4 cup TID (three times a day), add double supercereal at breakfast and lactose free milk (soy or rice milk OK) for nutritional problem.<br><br>Interview with the Nurse Consultant on 11/2/12 at 2:35 p.m., indicated the resident should not have been served 2% milk. She indicated he was to receive lactose free milk.<br><br>Interview with the Director of Nursing on 11/5/12 at 8:18 a.m., indicated cottage cheese should have been given to the resident as ordered by the physician.<br><br>3.1-35(g)(2) | | | |

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| F0309 SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>Based on observation, record review and interview, the facility failed to ensure non pressure skin conditions were assessed and monitored for 3 of 3 residents reviewed of the 3 residents who met the criteria for skin conditions non pressure related. (Residents #39, #68, and #98)<br><br>Findings include:<br><br>1. On 10/30/12 at 2:08 p.m., Resident #68 was observed picking at a scabbed area above his knuckle on his left hand.<br><br>On 11/1/12 at 9:27 a.m., and 2:59 p.m., the resident was seated in a chair in the Cottage dining room. The resident was again observed picking at the scab on his left hand.<br><br>The record for Resident #68 was reviewed on 10/31/12 at 2:07 p.m. The resident's diagnoses included, but were not limited to, diabetes and behavior disturbance. | F0309 | **F309 – Provide Care Services for Highest Well Being** It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #39, #68, #98* - physician and families have been updated and informed of each resident's current skin condition. Skin conditions have been assessed and monitored. Care plans and Nurse Aide Assignment Sheets have been updated to reflect each resident's current status. These residents experienced no negative outcomes related to this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents are at risk to be affected by this finding. Weekly | 12/05/2012 |

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| | A Physician's order dated 10/8/12, indicated the resident was to have bactroban ointment applied to the top of his left hand and to the top of his left arm twice a day for 10 days then discontinue, due to picking at the sore on the top of his left hand.<br><br>The Weekly Skin Summaries dated 10/8, 10/16 and 10/30/12, indicated the resident had no changes in condition since the last weekly summary. The form indicated the resident had "no skin areas."<br><br>The Quarterly Minimum Data Set assessment dated 9/4/12, indicated the resident had an open lesion other than ulcers, rashes and cuts.<br><br>The plan of care dated 9/20/12, indicated the resident was at risk for skin breakdown due to incontinence, decreased mobility due to the diagnoses of diabetes, heart disease, cancer, memory problems, and picks at skin. The interventions indicated the resident was to be encouraged/redirected to not pick at his skin and assess/document skin condition weekly and as needed. Notify the Physician of abnormal findings. | | Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. Any new skin issues noted such as bruising, discolorations or skin tears will be promptly investigated and followed up with to determine cause. In addition, A Non Pressure Skin Evaluation Report will be completed to ensure all skin areas are assessed and monitored closely until resolved. Shower Sheets and Weekly Summaries will be reviewed daily during clinical meetings by the Nurse Management Team/designee to ensure all current skin areas are noted on shower sheets and Weekly Summaries and any new areas are followed up with according to policy. A nursing in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the Skin Management Policy.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the Skin Management Policy. Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine | |

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| | Interview with LPN #2 on 11/5/12 at 10:45 a.m., indicated the issue with the resident's hand was reoccurring and should have been documented on the weekly skin assessment sheet.<br><br>2. On 10/29/12 at 12:36 p.m., Resident #39 was observed with a skin tear to his right elbow.<br><br>On 10/31/12 at 8:11 a.m., 9:18 a.m., 10:40 a.m., and 2:30 p.m., the resident was observed with a scabbed over area to his right elbow.<br><br>The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident's diagnoses included, but were not limited to, chronic anemia and dementia. An entry in the Resident progress note dated 10/29/12 at 7:19 a.m., indicated the resident was found by the CNA on the floor on his knees in his room. A superficial skin tear to the right elbow was observed, small amount bloody drainage, tiny skin tear to right index finger, and a small bruise and bump to the right knee was purple in color.<br><br>A Physician's order dated 10/29/12, indicated the resident was to have bacitracin applied to the right elbow and right finger three times a day for 7 days then discontinue. | | bathing and shower care. Shower Sheets and Weekly Summaries will be reviewed daily by the Nurse Management Team/designee during clinical meetings to ensure all current skin areas are noted on shower sheets and Weekly Summaries and any new areas are followed up with according to policy. Any new areas of impaired skin including bruising, discolorations and skin tears will be promptly investigated by the Nurse Management Team/designee and followed up with to determine cause. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Bruises" daily for 3 weeks, weekly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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The Weekly Skin Assessment dated 10/30/12, indicated the skin tears to the right elbow and right index finger were not identified.

Interview with LPN #2 on 11/5/12 at 10:58 a.m., indicated the skin tears were not documented on the skin assessment sheet dated 10/30/12.

3. Resident #98 was observed on 10/30/12 at 9:58 a.m. She had a bruise that was the size of a dime on the back of her left hand.

On 10/31/12 at 11:13 a.m., the bruise on the back of her left hand was 2 inches by 1 inch in size and was light purple in color.

On 11/1/12 at 10:15 a.m., the bruise was 2 inches in size.

The record for Resident #98 was reviewed on 11/1/12 at 8:45 a.m. The resident had diagnoses that included, but were not limited to, advanced Alzheimer's disease with behavioral disturbance and anxiety. The October 2012 Physician Order Sheet indicated the resident had orders for Aspirin 81 milligrams daily.

Review of the form titled, "Weekly

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| | Nursing Summary and Skin Assessment" dated 10/25/12, indicated the resident had no bruise. There was no evidence of a "Weekly Nursing Summary and Skin Assessment" in the record after 10/25/12.<br><br>Review of nursing progress notes dated 10/22/12 through 11/1/12, indicated there was no evidence the bruise on the back of the resident's left hand was identified, assessed and monitored.<br><br>The nursing care card, updated 10/30/12, indicated the resident was "at risk for bleeding and bruising."<br><br>Review of the form titled "Shower Report" dated 11/1/12, that was signed by the CNA and the Licensed Nurse, did not indicate the resident had a bruise on her left hand.<br><br>On 11/2/12 at 9:31 a.m., the bruise on the back of the resident's left hand was dark red in color and was 2 inches in size. Interview with LPN #1 at that time, indicated she first noted the bruise that morning, on 11/2/12. She indicated the resident had a recent lab draw and thought that might be the cause of the bruise. She indicated the resident was scheduled | | | |

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| | to have a "Weekly Nursing Summary and Skin Assessment" completed on 10/29/12. She indicated there was no evidence the skin assessment was completed on that day. She indicated the last "Weekly Nursing Summary and Skin Assessment" completed for the resident was dated 10/25/12.<br><br>The policy titled, "Skin Management Program" that was revised on 6/2012 was provided by the Nurse Consultant on 11/2/12. She indicated the policy was current. The policy indicated, "Residents will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity and skin impairment . . . Weekly skin assessments will be completed on all residents with or without alterations in skin integrity and documented on the weekly skin assessment form and/or nursing notes . . . Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include bruises, open areas, redness, skin tears, blisters and rashes."<br><br>Interview with the Nurse Consultant on 11/2/12 at 9:45 a.m., indicated there was no evidence that the bruise | | | |

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| | on the resident's hand had been identified, assessed and monitored. She indicated the shower sheet did not identify the resident's bruise and the "Weekly Nursing Summary and Skin Assessment" was not completed timely.<br><br>3.1-37(a) | | | |

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| F0323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interview, the facility failed to ensure a resident was safe and free from accidents related to positioning devices for 1 of 3 residents reviewed for accidents of the 6 residents who met the criteria for accidents. (Resident #36)<br><br>Findings include:<br><br>On 10/31/12 at 10:37 a.m., and 11:25 a.m., Resident #36 was observed sitting in a broda wheelchair in his room. The resident was observed with a hoyer lift pad underneath him. At that time, there was no staff in the resident's room. The resident was in the room with his roommate.<br><br>On 10/31/12 at 1:37 p.m., CNA #5 and the Third Floor Unit Manager was going to place the resident in bed using the hoyer lift. The resident was lifted by the hoyer and placed into the bed. At that time, there was no dycem (a piece of adhesive material to prevent the resident from sliding | F0323 | **F323 – Free of Accident Hazards/Supervision** It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #36* – has experienced no further falls. His fall care plan and Nurse Aide Assignment Sheet has been reviewed and updated to reflect his current status. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident identified as being at risk for falls has the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team to review all resident fall care plans. The prevention interventions on each resident's fall care plan will be compared to the Nurse Aide Assignment Sheet. In addition, | 12/05/2012 |

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| | forward) noted in the resident's chair. CNA #5 indicated at the time that she did know the resident was to have a dycem in his wheelchair. She further indicated she had laid him down after breakfast to change his brief and then placed him back into the wheelchair.<br><br>The record for Resident #36 was reviewed on 10/31/12 at 8:57 a.m. The resident's diagnoses included, but were not limited to, cataracts, high blood pressure, dementia, osteoarthritis, chronic pain syndrome, depressive disorder, and amputation of his arm.<br><br>Review of Physician Orders dated 10/26/12, indicated to utilize a broda wheelchair for positioning and comfort. Another Physician Order dated 10/18/12, indicated to add dycem to the wheelchair.<br><br>Review of the quarterly 10/1/12 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented. He needed extensive assist with a two person physical assist for bed mobility, transfers, personal hygiene, and dressing. The resident also had a history of falls.<br><br>Review of the 10/1/12 fall risk | | the DNS and/or designee will be responsible for daily environmental inspections on all shifts of all resident rooms and equipment. This audit will ensure all safety and fall prevention interventions are in place and properly being utilized. A nursing in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, “Fall Management Program”. This in-service will also include review of the care plan process and importance of adherence to established care plans and safe practices in regards to safety interventions such as positioning devices in wheelchairs and leaving residents unattended in rooms. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, “Fall Management Program”. This in-service will also include review of the care plan process and importance of adherence to established care plans and safe practices in regards to safety interventions such as positioning devices in wheelchairs and leaving residents unattended in rooms. In addition, | |

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| | assessment indicated the resident was at risk for falls.<br><br>Review of the fall screen completed by the Occupational therapy department dated 10/25/12, indicated the resident needs a hoyer lift times two assist for transfer. The resident resident has had three falls in the last quarter and was positioned in a regular wheelchair. The resident will be positioned in broda chair to improve comfort and positioning.<br><br>Review of the current plan of care dated 2/25/11, and updated on 10/25/12, indicated the resident was at risk for falls due to impaired functional ability, stroke, tends to fall asleep in wheelchair and will refuse to lay down, slides down in bed/chair, history of falls, and had a history of crawling out of bed. The Nursing approaches were to asses the resident when he was tired, therapy screen for a wheelchair, offer resident pajama pants, a scoop mattress, extra long high low bed to be kept in lowest position, do not leave unattended in wheelchair in his room, and a dycem in the wheelchair.<br><br>Review of Nursing Progress Notes dated 10/17/12 at 10:50 p.m., indicated the resident was found on | | the DNS and/or designee will be responsible for daily environmental inspections of all resident rooms and equipment on all shifts. Any change in resident safety needs will be identified during daily clinical meetings. Changes will be communicated by the Nurse Management Team/designee to direct care staff promptly through updates to care plans and Nurse Aide Assignment Sheets. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure compliance with these corrective actions, the DNS/designee will complete the CQI Audit Tool titled, "Fall Management" daily for 3 weeks, weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | the floor sitting up on the floor mat at 8:45 p.m. The bed alarm was sounding and the CNA went into the room and found the resident on the floor. The resident indicated he was getting up to get some pants from the closet.<br><br>The next documented fall was on 10/24/12 at 8:00 p.m., which indicated the resident had fallen out of bed. The resident was observed sitting on his knees on the floor mat next to the bed.<br><br>Nursing Progress Notes dated 10/25/12 at 1:00 a.m., indicated the resident was sitting up in a wheelchair in the dining room eating a snack when he leaned to this right side and landed on the floor on his right side. The CNA was in the dining room when the resident fell but could not get to him quick enough.<br><br>Interview with the Third Floor Unit Manager on 10/31/12 at 2:00 p.m., indicated the dycem had not been placed in this chair because it was a new chair for the resident.<br><br>Interview with Third Floor Unit Manager on 11/2/12 at 3:00 p.m., indicated the resident should not be left alone in his room due to his high | | | |

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| | risk for falls, and he should have a dycem in his wheelchair all the time.<br><br>3.1-45(a)(2) | | | |

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| F0325 SS=D | 483.25(i)<br>MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br>Based on observation, record review, and interview, the facility failed to ensure each resident maintained the acceptable parameters of nutrition related to supplements given as ordered for one resident with a history of weight loss and one resident with low protein levels for 2 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition. (Resident #31 and #137)<br><br>Findings include:<br><br>1. On 10/31/12 at 12:25 p.m., Resident #31 was observed in the dining room eating his lunch meal. At that time, the resident was served a pureed diet. The resident had a carton of chocolate milk and cup of an orange drink. There was no can of Ensure or another cup with the Ensure in it by his lunch tray. | F0325 | **F325 – Maintain Nutrition Status Unless Unavoidable** It is the intent of this provider to ensure that each resident (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #31* – has experienced no further weight loss and has been receiving the physician ordered supplement as well as fortified mashed potatoes with lunch and supper. The physician and the responsible party were made aware of this resident's current nutritional status. *Resident #137* – has experienced no weight loss and lab values are within normal limits. He has been receiving the | 12/05/2012 |

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| | On 11/1/12 at 12:50 p.m., the resident was observed eating his lunch in the dining room. The resident was served a pureed lunch that consisted of broccoli, noodle casserole, a breadstick, and a dessert. The resident did not receive fortified mashed potatoes. The resident was served a carton of chocolate milk and glass of fruit punch. The resident did not receive any Ensure supplement.<br><br>Interview with the resident at that time, indicated sometimes he gets the ensure sometimes he does not.<br><br>Interview with Dietary Aid #1 on 11/1/12 at 12:58 p.m., indicated she did not know if the resident was to receive the fortified mashed potatoes. She further indicated everyone who gets fortified foods also gets the regular entree as well.<br><br>The record for Resident #31 was reviewed on 10/31/12 at 1:59 p.m. The resident's diagnoses included, but were not limited to, anemia, osteoarthritis, chronic renal failure, stroke, and oral cancer.<br><br>Review of the Physician's Orders dated 10/12, with the original order date of 5/22/12, indicated the resident | | physician ordered cottage cheese at all meals. The physician and the responsible party were made aware of this resident's current nutritional status. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident with orders for supplements or nutritional enhancements have the potential to be affected by this finding. The DNS/designee will be responsible for completing a facility audit to review all residents with physician ordered supplements and/or dietary recommendations for nutritional enhancements such as cottage cheese or lactose free milk. These orders will then be compared to each resident's dietary card and Nurse Aide Assignment Sheet. Any discrepancies noted will be clarified and corrected at that time. The daily Dining Room Supervisor assigned to each dining room for each meal will monitor that physician ordered supplements and nutritional enhancements are provided as ordered and noted on each resident's dietary card. An all staff in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the policy related to Weight Management and supplement | |

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| | was to receive Ensure Plus eight ounces, 1 can at meals.<br><br>Review of Dietary Progress Notes dated 5/18/12, indicated the resident was to receive fortified mashed potatoes with lunch and supper.<br><br>Review of the weight record indicated on 7/5/12 the resident weighed 129 pounds, on 8/1/12 the resident weighed 125 pounds, on 9/6/12 the resident weighed 127 pounds, on 9/17/12 the resident weighed 125 pounds, on 10/9/12 the resident weighed 122 pounds, on 10/16/12 the resident weighed 117 pounds and on 10/24/12 the resident weighed 118 pounds.<br><br>The resident had a significant weight loss from 9/17/12 to 10/24/12 of seven pounds and 5.9%.<br><br>Review of Dietary Progress Notes by the Certified Dietary Manager dated 8/27/12, indicated the a nutrition risk assessment was completed. The assessment indicated the resident's current weight was 125 pounds and he was underweight. The note addressed the resident was below his Body Mass Index (BMI) and has had a slow steady weight loss. No recommendations were made at that | | and nutritional enhancement use. Any physician order or dietary changes will be reviewed and updated during daily clinical meetings. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** An all staff in-service will be held on or before 12/5/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the policy related to Weight Management and supplement and nutritional enhancement use. In addition, the daily Dining Room Supervisor assigned to each dining room for each meal will monitor that physician ordered supplements and nutritional enhancements are provided as ordered and noted on each resident's dietary card. Any physician order or dietary changes will be reviewed and updated during daily clinical meetings by the Nurse Management Team/designee. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with these corrective actions, the DNS/designee will complete the CQI Audit Tool titled, "Supplement" daily for 3 weeks, weekly for 6 months. She will also be responsible for completion of | |

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| | time.<br><br>The next Dietary Note was a Nutritional at Risk review dated 9/7/12, which indicated the resident was receiving chemotherapy and radiation. The resident's weight had remained stable at this time. No recommendations were made.<br><br>The next documented Dietary Progress Note was by the Registered Dietitian (RD) dated 9/17/12. The RD noted a change in condition with the resident. She indicated his food consumption was poor and he was still receiving treatment for his oral cancer. The RD indicated his weight range from 7/12-9/12 was 124-129 pounds. No recommendations were made at that time.<br><br>There were no other RD progress notes in the resident's clinical record.<br><br>The current 9/12 plan of care indicated the resident had the potential for alteration in nutrition related to being on a mechanically altered and therapeutic diet. The resident received supplements to help meet nutritional needs. The Nursing approaches were to provide adaptive equipment, provide supplements per Physician orders, monitor weights and | | the CQI Audit Tool titled, "Dietary Recommendations" weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 12/5/12. | |

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| | report significant weight changes to the Physician and family.<br><br>Review of the RD visits to the facility indicated she was there on 9/20, 9/27, 10/2, 10/3, 10/10, 10/16, and 10/30/12.<br><br>Interview with the Director of nursing on 11/1/12 at 8:10 a.m., indicated the resident had not been seen by the RD since 9/17/12. She further indicated the facility held a NAR meeting last night on 10/31/12 to discuss the resident's current weight loss. The Director of Nursing indicated the RD should have been notified earlier of the resident's weight loss from 9/12-10/12.<br><br>Interview with the Director of Nursing on 11/1/12 at 2:00 p.m., indicated the Ensure supplement was sent to the units by the dietary department and placed on the resident's trays.<br><br>Interview with the Consultant Dietary Food Manager on 11/1/12 at 2:00 p.m., indicated the Ensure supplement was to be placed on the food trays during the meal times from dietary. She further indicated she was unaware the resident was supposed to be receiving fortified mashed potatoes all along. | | | |

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| | 2. Resident #137 was observed on 10/31/12 at 8:29 a.m., in his bed. The resident had just received his breakfast tray. He was served 8 ounces of 2% milk (not lactose free), 2 bowls of hot cereal, eggs, sausage and grapefruit slices. He was not served cottage cheese.<br><br>On 10/31/12 at 12:40 p.m., the resident had his lunch tray, he did not receive cottage cheese.<br><br>On 11/1/12 at 12:45 p.m., the resident was eating lunch, he was served broccoli, ambrosia, garlic bread and chicken with spaghetti noodles. The resident did not receive cottage cheese.<br><br>The resident was in the Main Dining Room on 11/2/12 at 8:48 a.m. He had his breakfast tray. He was served lactose free milk, sausage and biscuit, 2 bowls of hot cereal and 2 boiled eggs. There was an eight ounce carton of 2% milk on his tray. There was no cottage cheese served to the resident. The Speech Language Pathologist was seated next to the resident.<br><br>Interview on 11/2/12 at 10:35 a.m., with the Speech Language | | | |

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| | Pathologist, indicated the resident liked cottage cheese. She indicated he was not served cottage cheese with his breakfast on 11/2/12. She also indicated he had a glass of milk and a carton of milk.<br><br>The record for Resident #137 was reviewed on 10/31/12 at 9:06 a.m. The resident had diagnoses that included, but were not limited to, end stage renal disease and hypertension. The resident received dialysis three times per week.<br><br>The plan of care from the dialysis center dated 9/20/12 indicated the resident was to receive dialysis three times per week. The goals as of 9/20/12 were:<br>-albumin (type of protein in the body) level to be 4.0 or more. The current level was 2.6<br>-potassium (an electrolyte in the body) level to be 3.8-5.5. The current level was 4.9<br>-phosphorus (a mineral in the body) level to be 3-5.5. The current level was 4.6.<br>-calcium (a mineral in the body) level to be 8.4-10.2. the current level was 9.8.<br><br>There was a care plan dated 10/30/12 that indicated: | | | |

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| | Potential for alteration in nutrition related to resident requires therapeutic diet related to end stage renal disease, hypertension and receives dialysis.<br>Some of the interventions included:<br>-fortified cereal at breakfast, cottage cheese three times a day and Nepro<br>-monitor weight<br>-diet per physician's order<br><br>There was a Physician Order dated 10/15/12, that indicated to add cottage cheese 1/4 cup TID (three times a day), add double supercereal at breakfast and lactose free milk (soy or rice milk OK) for nutritional problem.<br><br>Review of the resident's lab results dated 10/9/12, indicated the resident's calcium level was 9.8, (within normal limits) and the resident's albumin level was 2.5 (low).<br><br>There was a progress note dated 10/30/12, written by the Registered Dietician, that indicated the resident received Nepro twice daily, 1/4 cup of cottage cheese, double supercereal and lactose free milk.<br><br>Interview with the Nurse Consultant on 11/2/12 at 2:35 p.m., indicated the resident should not have been served | | | |

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| | 2% milk. She indicated he was to receive lactose free milk.<br><br>Interview with the Director of Nursing on 11/5/12 at 8:18 a.m., indicated the physician had ordered the cottage cheese to improve the resident's calcium and protein levels. She indicated the cottage cheese should have been given as ordered by the physician.<br><br>3.1-46(a)(1) | | | |

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| F0329 SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | | | |
| | Based on record review and interview, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs for 3 of 10 residents reviewed for unnecessary drugs related to having a diagnosis to support the use of an anti-psychotic medication, monitoring the apical pulse prior to giving a heart medication, and monitoring elevated blood sugars. (Residents #15, #68, and #84) | F0329 | **F329 – Drug Regimen Is Free From Unnecessary Drugs** It is the intent of this provider that each resident's drug regimen be free from unnecessary drugs.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #68* –physician has been notified of past and recent accucheck results and any accucheck results outside the physician ordered parameters. This resident experienced no negative outcome | 12/05/2012 |

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| | Findings include:<br><br>1. The record for Resident #68 was reviewed on 10/31/12 at 2:07 p.m. The resident's diagnoses included, but were not limited to, diabetes and behavior disturbance.<br><br>Review of the 10/12 Physician's Order Summary (POS), indicated the resident received 14 units of Humulin 70/30 insulin twice daily. On 10/31/12, the dose was reduced to 7 units twice daily.<br><br>A Physician's order dated 5/30/12 and listed as current on the 10/12 POS, indicated the resident was to receive accuchecks (a test to monitor the blood sugar) twice a day at 7:00 a.m. and 4:00 p.m. The Physician was to be called if the blood sugar was greater than 200.<br><br>Review of the August, September, and October 2012 Blood glucose monitoring sheets, indicated the resident's blood sugar was above 200 on the following dates and times, however, the resident's physician was not notified as ordered:<br><br>8/6 4:00 p.m., blood sugar 256, 8/25 4:00 p.m., blood sugar 216, and 8/29/12 4:00 p.m., blood sugar 214. | | related to this finding. *Resident #15* – physician has been notified of resident's pulse and blood pressure. Resident's apical pulse is being obtained and recorded prior to giving Digoxin. This resident experienced no negative outcome related to this finding. *Resident #84* – physician has been notified related to use of the Seroquel and clarification orders have been obtained regarding updated diagnosis. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident with orders for accuchecks, orders to obtain and record vital signs prior to medication administration and/or orders for psychotropic medications is at risk to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will review all residents with physician's orders for: accuchecks, obtaining and recording vital signs prior to medication administration and residents with orders for psychotropic medications. The Nurse Management Team will then review clinical records to ensure documentation is present and recorded as ordered, that physician's have been notified of any accuchecks outside the notification parameters and that all psychotropic medications have | |

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| | 9/8 4:00 p.m., blood sugar 244, 9/9 4:00 p.m., blood sugar 271, 9/12 4:00 p.m., blood sugar 238, and 9/23/12 4:00 p.m., blood sugar 207.<br><br>10/22 4:00 p.m., blood sugar 238 and 10/23/12 4:00 p.m., blood sugar 208.<br><br>Interview with the Assistant Director of Nursing on 11/2/12 at 9:40 a.m., indicated the physician should have been notified if the resident's blood sugar was greater than 200 as ordered.<br><br>2. The record for Resident #15 was reviewed on 10/31/12 at 9:33 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation (an irregular heartbeat).<br><br>A Physician's order dated 5/25/12 and identified as current on the October 2012 Physician's Order Summary (POS), indicated the resident was to receive Digoxin (a heart medication) 0.125 milligrams (mg) by mouth daily. The digoxin was to be held if the resident's systolic blood pressure (top number) was less than than 60 and the resident's pulse was to be checked.<br><br>Review of the October 2012 | | an appropriate diagnosis to support the use. The Nurse Management Team will be responsible for daily review of MARs and Blood Glucose Monitoring Records to ensure vital signs have been obtained and recorded prior to medication administration and physicians have been notified for accucheck results outside the ordered parameters. In addition, the Nurse Management Team will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as an appropriate diagnosis to justify the need for the medication. Orders will be corrected and clarified as needed. A mandatory nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy titled, Medication Administration Procedure including obtaining and recording vital signs prior to specific medication administration, Blood Glucose Monitoring with physician notification when appropriate and Psychoactive Medication Management Program. Nursing staff will be re-educated regarding clinical justification for use of any psychoactive medication as well as required and appropriate supportive documentation. **What measures will be put into place or what systemic changes will** | |

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| | Medication Administration Record (MAR), indicated there was no pulse documented prior to giving the medication on the following dates: 10/3, 10/7, 10/8, 10/9, 10/11, 10/12, 10/13, 10/14, 10/17, 10/18, 10/19, 10/22, 10/23, 10/24, 10/26-10/29, and 10/31/12.<br><br>The September 2012 MAR, indicated no pulse was documented on 9/3, 9/11, 9/13, 9/14, 9/24 and 9/25/12.<br><br>Review of the August 2012 MAR, indicated no pulse was documented on 8/8, 8/9, 8/10, 8/22, and 8/23/12.<br><br>Interview with the Assistant Director of Nursing on 11/2/12 at 9:45 a.m., indicated the resident's apical pulse should have been checked and documented prior to giving the digoxin. She further indicated a clarification order needed to be obtained related to the resident's blood pressure parameters.<br><br>3. The record for Resident #84 was reviewed on 10/31/12 at 8:44 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.<br><br>A Physician's order dated 9/12/12, indicated the resident was to receive | | **be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy titled, Medication Administration Procedure including obtaining and recording vital signs prior to specific medication administration, Blood Glucose Monitoring with physician notification when appropriate and Psychoactive Medication Management Program. Nursing staff will be re-educated regarding clinical justification for use of any psychoactive medication as well as required and appropriate supportive documentation. The Nurse Management Team will be responsible for daily review of MARs and Blood Glucose Monitoring Records to ensure vital signs have been obtained and recorded prior to medication administration and physicians have been notified for accucheck results outside the ordered parameters. In addition, the Nurse Management Team will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as an appropriate diagnosis to justify the need for the medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | |

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| | Seroquel (an anti-psychotic medication) 25 milligrams (mg) by mouth daily. The resident did not have a diagnosis to support the use of the Seroquel.<br><br>Interview with the Director of Nursing on 11/5/12 at 2:00 p.m., indicated the resident had been receiving the medication at home prior to admit and a diagnosis would be obtained to support the use of the medication.<br><br>3.1-48(a)(3)<br>3.1-48(a)(4) | | **assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the DNS/designee will monitor all new orders for psychotropic medications to ensure thorough and complete documentation is present as well as an appropriate diagnosis to justify the need for the medication. The DNS/designee will also be responsible for completion of the CQI Audit tools titled, “Unnecessary Medications” and ”Blood Glucose Monitoring” weekly for 4 weeks, then monthly for 6 months. In addition, the DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Medication Administration Record Review" weekly for 4 weeks, then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 12/5/12. | |

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| F0369 SS=D | 483.35(g)<br>ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS<br>The facility must provide special eating equipment and utensils for residents who need them.<br><br>Based on observation, record review, and interview, the facility failed to ensure each resident received adaptive equipment to facilitate their independence with eating related to a nosey cup for 1 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition. (Resident #36)<br><br>Findings include:<br><br>1. On 10/31/12 at 12:16 p.m., Resident #36 was observed in the dining room waiting on his lunch tray. The resident had three regular cups of thickened milk, thickened juice, and thickened water placed in front of him. The resident received his lunch tray at 12:41 p.m. At that time there were no nosey cups given to him to drink from. The resident started to feed himself and was observed to drink from the regular plastic cups. The resident's beverages were not placed into nosey cups during this meal.<br><br>On 11/1/12 at 12:40 p.m., the resident was observed in the dining room eating his lunch. The resident | F0369 | **F369 – Assistive Devices – Eating Equipment/Utensils** It is the practice of this provider to provide special eating equipment and utensils for residents who need them. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #36* – has been receiving his specialized drinking cup at meal times. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident with recommendations for use of specialized adaptive equipment, assistive devices and/or specialized eating utensils has the potential to be affected by this finding. The DNS/designee will be responsible for completing a facility audit. This audit will review all residents with recommendations for specialized adaptive equipment, assistive devices and/or specialized eating utensils. This information will then be compared to each resident's care plan and the | 12/05/2012 |

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| | had three regular cups of beverages in front of him. The resident did not receive any nosey cups for his drinks. The resident was observed drinking from the regular plastic cups.<br><br>At that time, the Consultant Dietary Food Manager, indicated the adaptive equipment is brought up to the dining room from the kitchen and it was the responsibility of the Nursing staff to pour the beverages into the nosey cups for the resident.<br><br>The record for Resident #36 was reviewed on 10/31/12 at 8:57 a.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), dementia, and esophageal reflux.<br><br>Review of the current plan of care plan updated 9/6/12, indicated the resident had a potential for alteration in nutritional needs related to receives a therapeutic and mechanically altered diet and honey thickened liquids due to diagnosis of diabetes and difficulty for chewing and swallowing. The nursing approaches were to provide with adaptive equipment a divided plate and a nosey cup.<br><br>Interview with the Second Floor Unit | | Nurse Aide Assignment Sheet. Any discrepancies will be clarified and corrected at that time. The daily Dining Room Supervisor assigned to each dining room for each meal will monitor that specialized assistive devices, eating equipment and utensils are utilized as recommended. Any changes related to specialized adaptive equipment, assistive devices and/or specialized eating utensils will be reviewed and updated during daily clinical meetings. A mandatory nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to use of adaptive equipment, assistive devices and specialized eating equipment and utensils for residents who need them. Staff will be re-educated regarding the importance of use of specialized adaptive equipment, assistive devices and/or specialized eating utensils to promote independence and to ensure that these items are provided as recommended.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to use of adaptive | |

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| | Manager on 11/2/12 at 1:09 p.m., indicated the resident should have had all of his beverages placed in the nosey cups.<br><br>3.1-21(h) | | equipment, assistive devices and specialized eating equipment and utensils for residents who need them. Staff will be re-educated regarding the importance of use of specialized adaptive equipment, assistive devices and/or specialized eating utensils to promote independence and to ensure that these items are provided as recommended. The daily Dining Room Supervisor assigned to each dining room for each meal will monitor that specialized assistive devices, eating equipment and utensils are utilized as recommended. Any changes related to specialized adaptive equipment, assistive devices and/or specialized eating utensils will be reviewed and updated by the Nurse Management Team/designee during daily clinical meetings.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit Tool titled, “Accommodation of Needs” daily for 3 weeks and then weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be** | |

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| F0412 SS=D | 483.55(b)<br>ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. | | | |
| | Based on observation, record review and interview, the facility failed to ensure dental evaluations were provided for 1 of 3 residents with broken or missing teeth who were reviewed for dental services, of the 4 residents who met the criteria for dental services. (Resident #64)<br><br>Findings include:<br><br>Resident #64 was observed on 10/30/12 at 10:12 a.m. The resident had a broken tooth on the upper portion of her mouth and her teeth were in poor condition.<br><br>The resident was observed on 11/1/12 at 3:41 p.m., and she was observed to have some missing teeth.<br><br>The record for Resident #64 was reviewed on 10/31/12 at 3:10 p.m. | F0412 | **F412 – Routine/Emergency Dental Services** It is the intent of this facility to provide or obtain routine or emergency dental services to meet the needs of each resident and must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #64* – received dental services on 11/13/12. The family and physician are aware of this resident's oral health status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be | 12/05/2012 |

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| | She had diagnoses that included, but were not limited to, dementia with behaviors and seizures. She was admitted to the facility on 12/11/10.<br><br>Review of the medical record indicated there was no evidence the resident had been evaluated by a dentist.<br><br>Review of the annual Minimum Data Set (MDS) assessment dated 1/31/12, indicated the staff was unable to examine the resident's oral/dental status at the time of the assessment.<br><br>Interview on 11/2/12 at 4:10 p.m., with the MDS Coordinator, indicated the resident had some broken and missing teeth.<br><br>Interview with the Social Service Director on 11/1/12 at 2:45 p.m., indicated the resident had not been evaluated by a dentist. She indicated she was not aware that residents were to receive routine dental care.<br><br>3.1-24(a)(1) | | affected by this finding and will be identified through a facility audit. This audit will be completed by the DNS/SSD/designee and will review each resident's current oral status. Any resident identified with difficulty chewing, poorly fitting dentures, sore mouth or broken/ missing teeth will be offered immediate dental services. In addition, all resident clinical records will be reviewed to determine those residents in need of routine dental services. Necessary dental arrangements will be made for any resident identified to be in need of routine dental services. Any signs of oral health concerns or changes in a resident's oral/dental status will be identified through daily ADL care by direct care staff including teeth brushing and/or during Weekly Nursing Assessments and reported timely through daily clinical meetings. Social Services will be responsible for scheduling, monitoring and following up with routine dental needs for all residents. An all staff in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to oral care and dental services. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be conducted by the DNS/designee on or | |

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| | | | before 12/5/12. This in-service will include review of the facility policy related to oral care and dental services. Staff will be re-educated regarding the process for addressing any oral or dental issues identified during routine care. Any signs of oral health concerns or changes in a resident's oral/dental status will be identified through daily ADL care by direct care staff including teeth brushing and/or during Weekly Nursing Assessments and reported timely through daily clinical meetings. Social Services will be responsible for scheduling, monitoring and following up with routine dental needs for all residents. Customer Care Rounds conducted by Department Leaders will inquire with residents/POA regarding satisfaction related to dental services. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DNS/SSD/designee will be responsible for completion of the CQI Audit Tool, "Dental Services" weekly for 4 weeks and monthly for 6 months to ensure this finding does not recur. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be** | |

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| F0425 SS=D | 483.60(a),(b)<br>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on observation, record review and interview, the facility failed to ensure residents did not receive expired medications related to Aplisol (Tuberculin) injections for 2 of 4 residents who received the Aplisol injections after the multi dose vials were opened. This had the potential to effect 48 residents who resided on the first floor. (Residents #138 and #139)<br><br>Findings include:<br><br>On 11/5/12 at 9:13 a.m., the first floor medication was observed. At that | F0425 | **F425 – Pharmaceutical Services** It is the practice of this facility to provide routine and emergency drugs and biological to its residents and to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #138* – has been discharged from the facility. *Resident #139* - physician and family have been updated | 12/05/2012 |

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| | 155115 | A. BUILDING 00<br>B. WING | 11/05/2012 |

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| | time, there were two multi dose vials of Aplisol 5/0. One of the vials had an open date of 9/20/12 and the other vial had an open of 10/3/12.<br><br>Review of the event reports for Resident #138 and #139 indicated the residents received an injection of the Aplisol from one of the multi dose vials on 10/26/12.<br><br>Review of the current 7/11 Drug Expiration Dating policy provided by the First Floor Unit Manager on 11/5/12, indicated multi dose vials expired 30 days from the date opened. Further review of the policy indicated Tubersol PPD/Aplisol vials expired 30 days after opening.<br><br>Interview with the First Floor Unit Manager on 11/5/12 at 9:15 a.m., indicated the Aplisol multi dose vials stored in the medication room were used for the residents.<br><br>Interview with the Nurse Consultant on 11/5/12 at 1:26 p.m., indicated there were four residents who received the Aplisol injections after the date they were both opened. She further indicated only two of those four residents received the medication after they had expired. | | regarding this resident's current status. The physician and Pharmacist were informed and the facility was instructed that it was not indicated to repeat the injection. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who receive Aplisol (Tuberculin) injections have the potential to be affected by this finding. The Aplisol (Tuberculin) vials identified in this finding have been discarded. The DNS/designee will complete an inspection of all medication rooms, medication room refrigerators and medication carts to ensure that any opened multi dose vials of medications have appropriate date opened stickers in place and are within the drug expiration date per manufacturer's recommendations. Any expired medications will be destroyed and/or discarded immediately. In addition, the DNS/Unit Manager/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturer's recommendations. A mandatory | |

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| | 3.1-25(a) | | nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to medication storage and expiration dates. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medication.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to medication storage and expiration dates. Nursing staff will be re-educated regarding applying a date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medication. In addition, the DNS/Unit Manager/designee will be responsible for facility wide weekly medication cart/room/refrigerator inspections. This will ensure that all medications are within the drug expiration date per manufacturer's recommendations. Any expired medications will be destroyed by | |

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| | | | DNS/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the DNS/SSD/designee will be responsible for completion of the CQI Audit Tool, "Medication Storage Review" daily for 3 weeks, weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 12/5/12. | |

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| F0463 SS=D | 483.70(f)<br>RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br>Based on observation and interview, the facility failed to ensure the call system was functioning for 1 of 40 resident call lights checked for function. (Resident #88)<br><br>Findings include:<br><br>The call light for Resident #88, was observed on 11/5/12 at 10:33 a.m., during the Environmental Tour. The gray pad call light had a crack in it. The call light was pressed, but it would not activate the light outside of the resident's room or at the nurses' station.<br><br>Interview with the Administer on 11/5/12 at 10:33 a.m., indicated the call light was not functioning and needed to be replaced.<br><br>3.1-19(u)(1) | F0463 | **F463 – Resident Call System – Rooms/Toilet/Bath** It is the practice of this provider that all nurse's stations be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident #88* – this resident's call light was replaced immediately with a functional call light. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The ED/Maintenance Supervisor/designee will be responsible for conducting a facility wide inspection of the facility call light system. Each call light will be tested to ensure proper function. Any noted issues will be corrected at the time noted. In addition, the facility | 12/05/2012 |

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| | | | will conduct Customer Care Rounds/Environmental Inspections daily. These Customer Care Rounds will include checking call light function in resident rooms, bathrooms and bathing areas. A mandatory all staff in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to notification to the Maintenance Department for repairs or maintenance needs.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory all staff in-service will be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to notification to the Maintenance Department for repairs or maintenance needs. The Maintenance Request Process will be reviewed with all staff. Staff will be re-educated regarding urgent needs for maintenance such as non-functioning call lights versus non urgent repair requests. In addition, the facility will conduct Customer Care Rounds/Environmental Inspections daily. These Customer Care Rounds will include checking call light function in resident rooms, bathrooms and bathing areas. Any | |

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| | | | environmental/repair issues noted during Customer Care Rounds will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the ED/DNS/designee will be responsible for directing the Customer Care Rounds/ Environmental Inspections daily for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 12/5/12. | |

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| F0465 SS=C | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to, dust in ceiling vents, marred and scratched chairs, marred, gouged and soiled walls, gouged and marred doors, missing light cords, loose toilet seat rails and toilet tissue holder, stained toilets, stained caulking and floor grout and broken tiles. This had the potential to affect 118 of the 118 residents residing in the facility in 3 of 3 units.<br>(First Floor, Third Floor and the Cottage Unit)<br><br>Findings include:<br><br>The following was observed during the Environmental Tour on 11/5/12 at 9:30 a.m., with the Administrator, the Maintenance Supervisor and the Housekeeping Supervisor:<br><br>1. On the Cottage Unit:<br><br>a. The bathroom between Room 1 and Room 3 had discolored floor tiles along the base board and the caulk | F0465 | **465 – Safe/Functional/Sanitary/Comfortable Environment** It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Cottage Unit:* · Floor tiles in bathroom between Room 1 and Room 3 have been repaired · Floor tiles and grout around cove base in bathroom between Room 2 and Room 4 have been repaired · Floor tiles in bathroom between Room 5 and Room 7 have been repaired and the safety rails around the toilet have been repaired · Floor tiles and rust stains in bathroom between Room 6 and Room 8 have been repaired · Floor tiles around toilet and beneath the sink in the bathroom between Room 9 and Room 11 have been repaired · Lime build-up around sink drain has been removed; rust stains in toilet bowel have been removed; toilet tissue dispenser repaired and pull cord replaced in the bathroom between Room 16 and Room 18 · Plaster wall in shower room on the Cottage Unit was | 12/05/2012 |

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| | around the base of the toilet was discolored. There was a dark black stain in the toilet bowl. 4 residents used the bathroom.<br><br>b. The bathroom between Room 2 and Room 4 had discolored grout around the floor tiles along the cove base. 4 residents used the bathroom.<br><br>c. The bathroom between Room 5 and Room 7 had discolored floor tiles around the baseboard. The safety rails around the toilet were loose and pulling away from the wall. 4 residents used the bathroom.<br><br>d. The bathroom between Room 6 and Room 8 had rust stains on the tile at the base of the toilet. There were red discolored floor tiles behind the toilet. 4 residents used the bathroom.<br><br>e. The bathroom between Room 9 and Room 11 had discolored floor tiles around the base of the toilet and underneath the sink. 4 residents used the bathroom.<br><br>f. The bathroom between Room 16 and Room 18 had a lime build up around the bathroom sink drain. There were rust stains in the toilet bowl. The toilet tissue dispenser was loose. There was no pull cord for the | | repaired and rust stains removed from shower stalls *First Floor:* · Room 128 – bathroom door was repaired · Room 115 – walls cleaned and room chairs repaired · Room 118 – room chairs repaired · Room 106 – room chairs and closet door repaired · Room 104 – room repainted; rust stains in toilet removed; room chair repaired *Third Floor:* · Room 316 – room door repaired · Room 320 – room chairs repaired; bathroom door repaired · Room 324 – room door and bathroom door repaired · Room 325 – room door repaired · Room 327 – room chair repaired; overbed string light repaired · Room 332/Room 333 – bathroom door repaired · Shower Room on First Floor edging and wall tiles repaired · All first floor hall vents cleaned **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. All resident rooms, bathrooms and bathing areas have been observed for the items listed above and all repairs were made where needed. In addition, the facility will conduct Environmental Inspections daily. These Environmental Inspections will include inspections/observations of resident rooms and bathroom such as floor tiles and bathroom | |

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| | bathroom call light. 4 residents used the bathroom.<br><br>g. In the shower room, there was a plaster wall that had an area that was 3 inches by 12 inches is size that was gouged and in need of repair. The walls of the shower stall were stained a rust color and were in need of cleaning.<br>31 residents resided on the Cottage Unit.<br><br>On the First Floor:<br><br>a. In Room 128, the bathroom door was gouged near the upper section of the door. 2 residents resided in the room.<br><br>b. In Room 115, the wall by bed one was soiled with food splatter. The room chair had marred legs and armrests. 2 residents resided in the room.<br><br>c. In Room 118, the room chairs had marred legs and armrests. 2 residents resided in the room.<br><br>d. In Room 106, the room chair had marred armrests and legs. The closet door had mars. 2 residents resided in the room and 2 used bathroom. | | fixtures in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed. A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to notification to the Maintenance Department and/Housekeeping Department for housekeeping issues, repairs or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory all staff in-service will be conducted by the ED/DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to notification to the Maintenance Department for repairs or maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. These | |

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| | e. In Room 104, the wall by the foot of bed 1 and bed 2 was marred and in need of paint. The legs and the armrests of the room chair was scratched and marred. There were rust stains in the toilet. 2 residents resided in the room and 4 residents used the toilet.<br><br>On the Third Floor:<br><br>a. In Room 316, the room door was marred and gouged. 1 resident resided in the room.<br><br>b. In Room 320, both room chairs had marred legs. The door on the inside of the bathroom was marred. 2 residents resided in the room. 4 residents used the bathroom.<br><br>c. In Room 324, the inside of the room door had a 3 inch by 3 foot area that was marred, the inside of the bathroom door had a 2 x 3 inch gouge. Two residents resided in the room.<br><br>d. In Room 325, there were mars on the inside of the room door. 2 residents resided in the room.<br><br>e. In Room 327, the wooden arms of the room chair were marred and scratched and in need of stain or | | Environmental Inspections will include inspections/observations of resident rooms and bathroom such as floor tiles and bathroom fixtures in need of repair. Any environmental/repair issues noted during these Environmental Inspections will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Process. The ED/designee will review Maintenance Logs/Requests and Housekeeping Request issues to ensure all necessary repairs and corrections have been completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action and to ensure the environment is safe/functional/sanitary and comfortable, the ED/DNS/designee will be responsible for directing the Environmental Inspections Audit daily for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Completion date = 12/5/12. | |

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| | paint. The string to the overbed light above bed 1 was broken. Two residents resided in the room.<br><br>f. In the bathroom between Room 332 and Room 333, the bottom 6 inches of both of the wooden doors on the inside of the bathroom were splintered. 3 residents used the bathroom.<br><br>g. In the Shower Room, the corner by the scale had broken edging and 2 broken wall tiles.<br><br>h. 5 of 5 ceiling vents in the halls of the unit, had an accumulation of dust. 39 residents resided on the Third Floor.<br><br>Interview with the Maintenance Supervisor at the time of the tour, indicated all of the above areas were in need of repair or cleaning.<br><br>3.1-19(f) | | | |